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MEDICAL ADVISORY COMMITTEE
(SCOTLAND)

REPORT ON VENEREAL DISEASES

Presented by the Secretary of State for Scotland to Parliament by Command of His Majesty

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Venereal Diseases Sub-Committee.

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Expenses of Committee.

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MEDICAL ADVISORY COMMITTEE (SCOTLAND)

To The Rt. Hon. Thomas Johnston, M.P.,
Secretary of State for Scotland.

Sir,

REPORT ON VENEREAL DISEASES

1. At our first meeting on 19th February, 1943, you stated that in view of the marked increase in venereal diseases, especially in certain areas, you would be glad of advice on how far propaganda might be helpful and on any new methods of approach. Subsequently, we appointed from among our number a Sub-Committee to consider (*a*) what further measures, if any, are necessary for the education of the public with regard to the dangers of venereal diseases and the need for early diagnosis and treatment, and (*b*) what improvements, if any, are required with regard to the arrangements for diagnosis, supervision, treatment and control of venereal diseases. The Sub-Committee held ten meetings in the course of which the experience and opinions of representative clinical and administrative experts were obtained in some detail. They visited various types of treatment centres, rural, urban and maritime, in order to acquire first-hand knowledge of the conditions under which clinics operate and the problems which are encountered, and at each place had informal but full discussion with the medical and lay staff.

2. We have indicated in the margin of our report by single vertical lines those recommendations which we consider are suitable for immediate adoption and by double vertical lines those which might be adopted at a later date.

THE INCIDENCE OF VENEREAL DISEASES IN SCOTLAND

3. Enquiry was directed in the first instance to the extent of venereal diseases in Scotland in order to measure what increase, if any, has occurred since the outbreak of war. An actual increase in venereal diseases had undoubtedly occurred but the incidence cannot be assessed as precisely as is possible for such infections as diphtheria, scarlet fever, etc. The mortality lists give no clue to the end results of syphilis or gonorrhœa ; deaths due to the remote sequelæ of venereal infection are commonly attributed to a non-specific pathology which masks the true causal factor. The available data by which morbidity can be measured refer only to patients dealt with at approved treatment centres, but what proportion of the total of infected persons is thus covered cannot be accurately estimated. The extent to which venereal diseases are treated outwith approved centres—and therefore not included in official statistics—is not known. We have reason to believe, however, that nearly all cases of syphilis are referred to clinics, but with the advent of sulphonamide therapy there is a possibility that an increasing number of gonorrhœal infections are being treated by private practitioners.

4. Although they provide a measure of the number of persons who acquire infection within any one year, the official returns include persons who are recorded as " new cases " by more than one centre ; this occurs especially as regards seamen whose treatment in a given year may be spread over several clinics. We regard it as essential that each case should be so identified and recorded that it will be included as a " new " case in the returns of one centre only. The returns from Local Authorities, interpreted in broad terms rather than in statistical detail, may, nevertheless, be taken on the whole as a reliable index of the trend of venereal diseases.

5. **Syphilis.**—During the 17 years prior to the war, the annual number of cases of syphilis commencing treatment at approved centres fell gradually from 5,000 in 1922 to 3,000 in 1939 (see Appendix—Fig. 1). During this period the figure for late syphilis exceeded the combined total for primary and secondary syphilis. After 1939 the figures rose progressively to nearly 5,000 in 1942 and the increase has been maintained during the first half of 1943. The numbers for primary and secondary syphilis taken together have risen from 1,000 in 1939 to 3,700 in 1942, greatly outnumbering those for late syphilis (see Appendix —Table I).

It may safely be presumed that some 9,000 persons in Scotland acquired syphilis during the period 1939–1942. A disquieting feature of the increase is the disproportionate number of young people between the ages of 15 and 25 who acquired the disease (see Appendix—Table II).

6. **Gonorrhœa.**—Cases of gonorrhœa increased from 4,000 in 1922 to a maximum of 7,000 in 1929, thereafter declining gradually and irregularly to 4,300 in 1939 (see Appendix—Fig. 2). A wartime rise occurred in 1941 (6,500 cases) with a slight fall to 5,800 in 1942. During 1939–42 new cases of gonorrhœal infection probably numbered about 21,000, four-fifths of whom were males, and within the 15–25 age-group the same disproportionate increase occurred as we have noted in connection with syphilis (see Appendix —Tables I and II).

7. **Congenital Syphilis.**—Congenital syphilis is definitely on the decline. Over the past decade, the yearly figure fell from 641 in 1933 to 319 in 1942 but the decrease only became marked in 1939 since when it has been progressive. We have noted that in all age groups the proportion of males is only one half that of females, a striking fact for which we have been unable to obtain a satisfactory explanation. The reduction affects all age groups up to 25, that occurring in the 0–1 age-group being of particular significance, and the evidence suggests that the encouraging results are a direct consequence of the work done at ante-natal clinics (see Appendix—Table III).

8. **Ophthalmia neonatorum.**—Notified cases of ophthalmia neonatorum during the past 10 years showed a moderate fluctuation until 1939 when a slight but definite downward trend appeared. As notifications include all types of inflammatory conjunctival lesions it is impossible to ascertain the proportion due to gonococcal infection (see Appendix—Table IV). We are assured, nevertheless, that the number of cases of gonococcal ophthalmia is now relatively small.

9. **Soft Chancre.**—Soft chancre is not a disease of major importance, the average annual figure representing about 200 males ; females scarcely ever come to clinics for treatment.

10. **Non-specific conditions.**—Each year some 2,500 patients are treated for non-specific venereal infections and a further 5,000 persons on examination are found to have no actual venereal disease. The majority of these 7,500 persons may be regarded as having run the risk of contracting syphilis or gonorrhœa and therefore must be included in any assessment of the problem of venereal diseases in respect of preventive propaganda and of the necessary provision for clinical investigation and observation.

11. Detailed tables prepared from the official returns and graphs showing the trends in the older and younger age-groups included in the Appendix are worthy of study.

12. We have already noted that the official returns do not represent the total number of infected persons in the country and there is evidence pointing to the fact that, although they probably constitute a small percentage of the population, a considerable number have venereal disease without being aware of it. We are of opinion that routine tests on a large scale would bring to light a sensible amount of syphilitic infection hitherto undetected which, if treated, would reduce morbidity and lessen infant mortality.

13. The situation during the war period 1939–1942, stated in round numbers, may be summarised thus :—

	1939	1940	1941	1942	*Total*
Syphilis, new cases . .	1,000	1,400	2,700	3,700	8,800
Gonorrhœa, new cases . .	4,000	4,500	6,000	6,000	20,500
Non-specific venereal infections	2,800	2,700	3,200	2,600	11,300
Patients with no venereal disease	4,000	3,800	4,500	5,000	17,300
					57,900

In other words, over the past four years at least 58,000 persons in Scotland were admittedly exposed to the risk of acquiring infection and 29,000 contracted a major venereal disease.

During 1942 alone, we estimate that on an average in Scotland *on every day of the year* 10 persons contracted syphilis and at least 16 contracted gonorrhœa.

14. The increase is more marked in the seaports and large towns and there is little evidence that there is any considerable increase in the country areas ; in fact, in some burghs there is a slight diminution in the number of cases of gonorrhœa. The data suggest that an appreciable part of the national increase is due to a temporary influx of cases among Service personnel and seamen ; in one seaport, for example, the number of cases of syphilis in 1942 was 11 times the pre-war figure but, after deduction of the maritime and Service cases, the number was but slightly above the pre-war average.

15. It would appear therefore that the increase in venereal diseases is an effect of wartime conditions and that a decline will occur in all probability when normal conditions return but we are of opinion, nevertheless, that the situation is sufficiently serious to warrant swift and energetic action by the authorities.

EDUCATION AND PUBLICITY

16. To eradicate venereal diseases completely from civilised communities will require international co-operation and a high standard of enlightened citizenship, but there is no reason why they should not cease to be a scourge in our own country within a very short time if a concerted and persistent effort is made. The precise ætiology and methods of spread of these diseases is known ; they can be accurately diagnosed and effectively treated, but no campaign against venereal diseases will avail without the moral sanction and active co-operation of the general public.

17. Until recently, however, a lack of plain speaking and an unwillingness to face the facts fostered an attitude of public inaction. It was assumed that public opinion would not support a campaign against venereal diseases and we

have been told that before the war the press would not print nor would the Church preach the truth about the evils and dangers to be avoided. There is evidence, however, to show that during the past year the public have shown a desire to be informed about venereal diseases and their control.

18. From our enquiries we must conclude that, largely because of public indifference and a definite hostility on the part of some, educational effort in the pre-war years was perfunctory and lacked direction and determination. From 1919 onwards a few earnest workers sought to interest local authorities and others in preventive measures but with very few exceptions the response was ineffectual, and often where the need appeared greatest public opinion was not sufficiently alive. Prior to the present war the educational programme was severely handicapped by the almost universal ban, already referred to, imposed on the most elementary publicity and even to-day among those who might be expected to be better informed, there is lamentable ignorance of the facts about venereal diseases, how they are acquired, how they can be prevented or cured. We believe that the public will respond now to sound practical advice and courageous leadership.

19. That the propaganda campaign inaugurated in January of this year has had an effect is shown by data submitted to us by the Venereal Diseases Officers of Glasgow, Edinburgh, Dundee and Aberdeen.

Abstract of returns of new cases January-June 6 year survey—1941-42-43.

		Non-V.D.	*Syphilis*	*Gonorrhœa*
Glasgow	1941	483	562	991
	1942	643	672	914
	1943	1,387	801	954
Edinburgh	1941	336	273	379
	1942	388	367	433
	1943	563	402	406
Dundee	1941	125	77	257
	1942	245	194	300
	1943	418	221	390
Aberdeen	1941	93	216	297
	1942	98	243	251
	1943	174	266	291

Comparing the first six months of 1943 with the corresponding period in 1941 and 1942 it is apparent that not only has there been a definite rise in the number of cases coming for treatment, but also a much more significant increase in the number of persons found to have no venereal disease. This shows that the propaganda campaign has had a measure of success and, in our view, the posters and advertisements appearing during the past few months have contributed to an increase of knowledge among the general public. It is a question, however, whether the person who is not socially conscious has been sufficiently affected by the campaign and whether other means may not have to be devised to get such people interested and co-operative.

20. The sociological import of venereal diseases lies in the fact that, if untreated or neglected, they take toll not only of the infected individual but of contacts and of offspring. It is clearly in the national interest that the family and the home be protected against the ravages of these infections. The social and moral problem is one not merely for social and religious organisations but

also for every home and every citizen ; education and propaganda must therefore be addressed to the individual as well as to the community as a whole.

Subject Matter for Publicity.

21. We have given much thought to the subject matter necessary for effective communal propaganda and for the personal education of the individual, a question on which we have found general agreement among the medical and lay experts with whom we have conferred. Educational matter must be factual, prepared by competent people, and presented in the form of simple direct statements, to the effect that venereal diseases are infectious, that they can be avoided and that if promptly treated, they can be cured. We note that official propaganda during recent months has progressively developed along these lines.

22. In the forefront must be placed the primary fact that in the overwhelming majority of instances syphilis or gonorrhœa is acquired by illicit sexual contact with an already infected person. Those who contract a venereal infection through no fault or responsibility of their own, though still too many, are in the minority. Illicit intercourse must always be regarded as potentially dangerous and promiscuity is the real breeding ground of venereal disease. The best method of prevention is the observance of personal chastity which means abstinence from exposure to infection, a chaste life being the one real protection against venereal disease. Although it is essential to avoid creating undue alarm, we are of opinion that it would be beneficial if young people, in prizing the possession of a healthy body, developed a healthy balanced fear of contracting venereal disease as part of a sane conception of clean living.

23. The education of those who acquire disease or who have run the risk of infection requires special attention. They should be told clearly what to do and where to go for advice and help, that delay is dangerous but that prompt and thorough treatment is effective and that strict confidence is observed. An individual who has been exposed to the risk of infection should be advised to seek skilled advice at once and exact information should be available indicating where such advice may be obtained. Once the patient is brought under medical care, a sympathetic but intensive personal education should begin with the object of securing full co-operation and confidence.

24. Persons already infected should be advised to report immediately to a doctor and to make no delay by any attempt at self-treatment. A simple description of the early manifestations of disease is advisable, and the warning should be given that an individual exposed to risk should report at once to a doctor if any sore, swelling, pain or discomfort appears in the genital area. Every infected patient must be instructed as to the need for continued treatment until cure is established. He should be warned of the danger to others during the infective period, especially through sexual intercourse, and the dangers of default should be pointed out as they may affect himself, his wife and unborn children.

Prophylaxis.

25. The highly controversial subject of prophylaxis has aroused considerable discussion at our conferences. There is full agreement that, if given under strict medical supervision within 24–48 hours after exposure, a " suppressive " course of sulphonamides, with perhaps the addition of some local treatment, can prevent the onset of gonorrhœa. Such treatment, of course, must be followed by continued observation over a period of at least three months together with serological investigation lest syphilis supervene. In experienced hands this

procedure is most efficacious and its desirability is not in question. On the other hand we have been assured that infection can be prevented by taking simple precautions either before or immediately after exposure to infection. There may be a certain danger, however, that prophylaxis may engender a false sense of security, especially where it is not used promptly and thoroughly. If properly carried out prophylactic cleansing should be of value in the male but effective cleansing and disinfection of the female is a much more difficult problem.

26. Where an individual is prepared to take the risk of infection, the consequences are so fraught with danger that we found ourselves in a dilemma as to whether the heedless person should be advised about precautions which might be taken. Prophylactic measures may be held to offend the social and moral code, and the opinion of some appearing before the Sub-Committee was against any advice being given about prophylaxis. After mature reflection we cannot, on purely medical grounds, agree with this view because it would seem to us to be unfair, if effective methods are available, to withhold this knowledge from the public, but we realise that other weighty aspects of the problem must be considered before any final conclusions can be formed.

Means of dissemination of Knowledge.

27. Without doubt the press has played an important part in the current propaganda campaign but we are of the opinion that more could be done by disseminating information as news and in the form of advertisements in newspapers and periodicals. Those for whom the propaganda is most urgently needed may not read the material in the better-known daily papers, and it has been represented to us that a wider circulation of information through more newspapers would be of great advantage.

28. The cinema and radio are two important channels of education of which more use can be made. Short films, well acted and skilfully produced should supplement the periodic display of brief notices drawing attention to the principles of healthy living and the dangers of venereal diseases. On the radio there should be frank talks by men and women in responsible positions and occasional broadcasts on the lines of that given by Sir Wilson Jameson would be of the greatest service, not only in sustaining public attention but in removing the prejudice and false modesty which so severely handicapped propaganda work in the past.

29. Local Authorities should continue to display posters, not only within their premises but also in prominent public sites; such posters should be designed to arrest public attention. We also suggest that Medical Officers of Health should arrange for leaflets containing advice and full information to be made available at public health departments and such other places as local circumstances permit.

30. So far as adults generally are concerned we are of opinion that propaganda will prove of value only if on a national basis. If they are not sufficiently warned by what they read, see and hear from press, cinema and radio, we entertain little hope of the adult population ever being influenced.

31. The suggestion has been made that intensive propaganda may engender undue fear and alarm in the public mind but we find no evidence that the public have reacted in this way to the present campaign. Indeed, considering that many will not submit to examination and treatment for any other reason than

fear of having acquired infection, we consider that to arouse a healthy element of fear is necessary for the success of the campaign against venereal diseases. It has also been suggested that sustained propaganda may create that familiarity which leads to indifference. In our view it would be better if the public were led to adopt a similar attitude towards venereal infection as they do towards the ordinary infectious diseases, in which event the morbid interest and prejudice with which venereal diseases are regarded would disappear.

Education of the Young.

32. The various opinions expressed to us about what ought to be done in the case of children and adolescents have been the subject of much thought and deliberation. In Scotland some 80,000 children leave school each year at the age of fourteen and the question arises how far it is profitable to give education involving sex matters at that age. There is no doubt that biology and hygiene form a valuable part of the ordinary curriculum but, in our view, any suggestion for the teaching of sex in schools requires the closest scrutiny because sex instruction to children at the age of 14 or 15 is fraught with difficulties and dangers. This is more so in the case of boys, because with girls the experience of menstruation and courses of instruction in mothercraft provide an opportunity for giving judicious instruction in sex hygiene. In our opinion it would be better if schools dealt with *health* education rather than with sex education. The routine science course might profitably be extended to include physiology thus laying a foundation and preparing the way for instruction in sex matters at a later age.

33. Teachers in training should receive careful instruction in the several aspects of elementary hygiene to fit them for their part of responsible duties. They should not be ignorant of the problem of venereal diseases but, save in the case of some teachers of senior pupils, they should not be called upon to teach anything bearing upon this subject.

34. In advanced secondary schools and in youth organisations instruction should deal not with sex hygiene as such but rather with rules for clean living, in which connection suitable reference could be made to the moral and physical dangers of promiscuity. Broadly speaking the object should be to direct the natural urges of human nature by causing knowledge to take the place of curiosity.

35. We would emphasise the danger of all such instruction to adolescents unless it is done in a most careful way by persons endowed with the ability and personality to undertake this important work. Experienced trained nurses carefully chosen for the purpose could be employed with advantage to instruct senior girls, and it is for consideration whether they could not usefully give talks to senior boys on matters concerning healthy living. All arrangements for imparting sex education to young people should be under the guidance of the Scottish Health and Education Departments and a greater use should be made of the school medical services as an educational unit. It will be necessary to gain the confidence and goodwill of parents, many of whom will be opposed to the idea, and others of whom are not fitted at present to advise their children. Parent-teacher associations and youth organisations can provide suitable opportunities for promoting the doctrine of health but, to deal with the more delicate questions of abstinence and the dangers of venereal disease, the help of selected male and female medical practitioners should be invited.

The responsibility for promoting education and publicity.

36. The Department of Health for Scotland should be primarily responsible for the promotion of national propaganda. They may find it helpful to utilise the services of interested voluntary bodies, but the primary responsibility should not be delegated. Medical Officers of Health have an important part to play in adapting the national campaign to the particular circumstances of their areas, in securing the co-operation of the medical profession and in co-ordinating local effort. As the problem of venereal diseases is as much moral as medical, the Church should be pressed to attack the moral side of the question fearlessly in straightforward, outspoken teaching. With a defined national policy embracing a guided programme of local effort we see no reason to doubt that success will follow. We take the opportunity of emphasising that the Government Departments concerned, especially the Department of Health for Scotland, should take an active part not only in directing schemes for the instruction of the public but also in seeing that these are effectively carried out.

MEDICAL ORGANISATION

37. Once we had taken the measure of the incidence of venereal diseases we examined in detail the facilities available for prevention, diagnosis and treatment in order to assess whether they were sufficient in extent and efficient in their operation. In accordance with the Public Health (Venereal Diseases) Regulations (Scotland) 1916, statutory facilities are provided by County Councils and the Town Councils of large burghs, singly or in combination, under schemes approved by the Department of Health for Scotland, which include the provision of (*a*) laboratory examinations, (*b*) free treatment, (*c*) the supply of drugs for treatment and prevention, (*d*) specialist assistance, and (*e*) educational propaganda. We have already commented upon the educational problem and given our recommendations for improvement.

Laboratory Facilities.

38. At the outbreak of war the organisation of laboratory facilities for the venereal diseases service became associated with the Emergency Bacteriological Service, each clinic being related to a designated laboratory. Four local authorities have their own laboratory services and other areas have arrangements with the laboratories of medical schools and certain of the larger voluntary hospitals. It has been suggested to us that facilities for serological tests are not sufficient to give timeous results ; we have been told, for example, how seamen have had to wait from a Thursday until the following Tuesday before the laboratory report came to hand, in consequence of which ships have been held up.

39. Laboratory investigations, often of a very complex nature, play almost essential part in the diagnosis and treatment of venereal diseases, the carrying out and interpretation of which demand highly skilled and experienced personnel. We recommend that the venereal diseases service be closely correlated with an extended regional laboratory scheme, designed to utilise not only existing laboratories but those set up in connection with the Emergency Medical Service.

40. As a sound insurance for the establishment of healthy families we recommend more widespread serological testing of pregnant women and we feel that the medical profession are not sufficiently alive to the value of blood tests in the course of detailed clinical investigation. Such routine tests should not be associated in the public mind with venereal diseases but as an integral part of a complete clinical examination.

Treatment Centres.

41. Free treatment is provided at 50 centres in Scotland. From our own observations, together with the evidence submitted to us, we must conclude that with certain exceptions, the existing facilities are not wholly satisfactory. We have seen treatment centres located in most undesirable sites, affording no privacy from the public gaze, difficult to find, and liable to discourage patients from attending for investigation and from persevering with treatment.

42. The geographical distribution of clinics is not satisfactory and the number is insufficient and, as will be seen from the map, wide areas have no treatment centre at all (see Appendix). We recommend that further arrangements be made in local hospitals and public health clinics for the service of venereologists and special practitioners and in this connection our recommendations regarding the integration and unification of the venereal diseases service may prove of value.

43. We consider that the Central Department and Local Authorities should accept certain desiderata for the efficient working of treatment centres, and we have embodied in our comments certain broad standards and principles which should apply to all clinics. Where in a given case this is impracticable the existing centre should be replaced in its entirety.

44. We deem it inadvisable that the treatment of venereal diseases should be carried out in any building so situated as to be associated in the public mind solely with venereal diseases. A treatment centre should be housed within a general hospital (or its out-patient department), a general clinic of a public health department or, possibly, a Health Centre, and arrangements for entrance and registration on admission should be indistinguishable from those for non-venereal patients. The managements and staffs of general hospitals should be urged to recognise that the diagnosis and treatment of venereal diseases are as important as those of other ailments and that to discourage or even resent the inclusion of a venereal diseases unit within a hospital, when public need so requires, is not in accordance with an enlightened policy.

45. Until concrete proposals are available for the establishment and use of Health Centres, we purposely refrain from discussing in detail how far such Centres could assist in the venereal diseases service. We think it right, however, to point out that they may solve difficulties met with under the present system.

46. We consider the first principles governing lay-out are privacy and adequate standards of accommodation and equipment. As with arrangements for admission, waiting-room accommodation should be such as to avoid discrimination between those attending the venereal diseases department and other patients. Where special waiting-rooms are necessary for the sole use of the venereal diseases service, reasonable standards of comfort should be provided and at any given time the number in attendance in a common waiting-room should be as small as is practicable by the adoption of some system of attendance by appointment to suit local conditions in a given area. We regard with strong disfavour bare waiting-rooms with rows of forms ; to herd the adolescent with the hardened case is most undesirable and such conditions must tend to discourage patients from persevering with treatment.

Clinical examination rooms should provide full privacy for the individual patient and technical equipment must be of a standard to allow adequate examination and proper aseptic technique. We are aware that certain approved centres do not fulfil these requirements.

47. We do not advocate any particular system for the internal working of a clinic but it cannot be too strongly emphasised that patients must be handled with a consideration and tact calculated to engender confidence and encouragement. In one sense the success or failure of a clinic will depend upon the attitude adopted towards the patient by all concerned ; patients are unlikely to persevere with treatment in an unsympathetic atmosphere. To see that the correct atmosphere is maintained is a duty which should normally devolve upon the Medical Officer of Health.

48. We consider it an important duty of the clinical staff to ensure that, without creating undue alarm, every patient is impressed with his obligation to himself and to the community to submit faithfully to the treatment prescribed, to abstain from infecting others, and to assist in bringing contacts under medical care. Having regard to the fact that a considerable time is required for the full investigation of a new case we recommend that, in the larger centres at least, the medical staff should be relieved of much time-consuming recording by the appointment of trained lay personnel to take preliminary case histories.

49. The medical officer in charge of a clinic should be a person with special training and experience in venereal diseases and junior medical staffs should work under the supervision and systematic instruction of experienced seniors. Particularly in the larger centres, the services of consultants in other specialities (e.g. dermatology, cardiology, neurology, etc.) should be made available to venereal diseases officers and conversely it is of especial advantage that gynæcological clinics should work in close co-operation with a venereologist. Wherever circumstances permit it is advisable that female patients should be under the care of female doctors, and should receive their treatment in clinics dealing with female ailments in general, rather than in a special venereal diseases department.

50. To ensure a steady supply of competent medical officers we recommend that arrangements be made by local authorities and the Central Department whereby practitioners assigned for work under the venereal diseases service, either in clinics or in the general medical service, should have special training, to be renewed at stated intervals where practicable. We lay great stress on the principle that the non-medical technical staff at a clinic should undergo a period of training at an approved centre, a subject to which we refer in more detail (paras. 60–62).

51. The immediate responsibility for maintaining an adequate venereal diseases scheme in a given area must rest with the Medical Officer of Health. In a centre directly under his administrative control, there should be no inherent difficulty in ensuring that facilities and staff are of the necessary standard, but where a clinic is not directly under his supervision, an arrangement is necessary to ensure that the work is carried out in close co-operation with him and that he can be satisfied that the staffing and clinical facilities are adequate. Where an arrangement has been made with an institution for the treatment of venereal diseases, the Local Authority should revise their agreement to ensure conformity with the above recommendations.

52. The control of venereal diseases being a matter of national importance, we consider that the Department of Health for Scotland should act as a supervisory and unifying authority, keeping in close and constant touch with venereal diseases officers and clinics. The Department should sponsor the dissemination of new knowledge and should ensure that each venereal diseases officer is supplied with current information. Venereal diseases officers should also be given an

opportunity from time to time to attend conferences convened by the Department to discuss the problems arising in connection with control and treatment.

The General Practitioner.

53. We have been informed that there has been no great tendency for private practitioners to treat syphilis or, prior to the advent of sulphonamide therapy, to treat gonorrhœa. The danger of treatment in private practice is that it may be incomplete, with the patient left in an infective state ; in clinics the treatment can be more thorough and the follow-up better. In rural areas, however, there is a problem created by distance and the time involved in travelling whereby the patient may have to be treated by the family doctor who may lack facilities and, perhaps, the necessary knowledge and skill.

54. In examining the role of the general practitioner in a venereal diseases service we have kept in mind that at all times proper laboratory control is essential for diagnosis, treatment and assessment of cure, and that expert clinical opinion is necessary to relate laboratory findings with the clinical picture, and to advise on the kind and amount of treatment required for the individual patient. Our proposals for legislation and administration envisage the closest relationship between the family doctor and the technical resources of the venereal diseases service.

55. Wherever local facilities are available at a clinic or local hospital, we advise that the family doctor should refer all cases to a treatment centre. This will apply in most towns but any development of health centres may provide an opportunity for those general practitioners, who so wish and who care to fit themselves for the task, to take an active part in clinical work in co-operation with local venereologists. Where treatment at a centre is impossible the family doctor will have to undertake the management of the case but arrangements should be made to place at his disposal expert clinical and laboratory resources for his guidance throughout treatment and for the establishment of cure.

56. We recommend that post-graduate courses for practitioners should be designed to enable them to undertake treatment under conditions of full co-operation with venereologists and the Medical Officers of Health. Furthermore, the Department of Health for Scotland should issue to every practitioner a brochure setting out concisely his obligations and duties, advice as to procedure, and a reliable schedule of treatment suitable for use in private practice ; the principle of specialist supervision should obtain throughout, with modifications to suit specific areas.

57. Close and continuous liaison is necessary between all practitioners and the Medical Officer of Health who should ensure that all doctors in his area are periodically kept informed of local facilities.

58. The private practitioner must be encouraged to co-operate in the work of contact finding and of persuading defaulters to resume treatment. He should be urged to be on the watch for venereal infections, and to make full use of bacteriological and serological services especially in pregnancy and in gynæcological cases.

59. As regards medical training we feel that courses for undergraduates should be such as to equip them to enter practice with ability to participate in treatment on the lines we have indicated above for general practitioners. In addition, students should be taught the principles and methods of prevention and control.

Non-Medical Personnel.

60. Brief reference has already been made to the need for trained technical staff at clinics (para. 50). Pupil nurses require instruction on the same lines as medical students with the necessary modifications to meet their professional need. To ensure adequate nursing staff for the venereal diseases service a larger number of nurses and health visitors will need special training, with refresher courses at intervals, to enable them to work not only within a centre, but also in contact finding and in the handling of defaulters. District nurses will require similar training to enable them to participate in the arrangements for treatment in rural areas.

61. The large clinic is incomplete without male orderlies whose duties in relation to male patients are similar to those of nurses. Male orderlies with the personality and experience necessary for successful work are hard to find and we advise that a steady supply be provided by the systematic training at approved centres of carefully selected men. We recommend that the status and scale of remuneration of these men should be such as to attract the right type of person.

62. For the social side of the work, particularly in regard to follow-up and rehabilitation, the venereal diseases service of a Local Authority should include either an almoner who has had clinical training or specially selected nurses trained in social welfare.

CONTACTS AND DEFAULTERS

63. It is not enough to provide the means for diagnosis and treatment; patients must be brought in, kept under treatment till cured and their source of infection and contacts located.

Propaganda and the education of both the lay and medical public are the means whereby more patients will be encouraged to seek treatment. Once a patient is seen it should be impressed upon him that he has an obligation not only to himself but also to his contacts. For every known case there is at least one other infected person who, in theory at least, can be located by the help of the patient. We are of opinion that the most effective approach is to impress upon the patient the danger of allowing his contacts to remain untreated, and to enlist his co-operation in obtaining for them the same care and attention that he himself is receiving. By this means the patient may take an active part in a course of action which is humanitarian in its emphasis and which carries with it no stigma of accusation or recrimination.

64. We have seen for ourselves that some clinics make a definite attempt to trace contacts in every case and that in others these duties are only perfunctorily performed. We consider that no clinical record is complete unless it records the fact that the necessary steps have been taken to locate contacts and, similarly, that no case can be regarded as successfully concluded until contacts have been brought to treatment. It is the duty of every practitioner treating a case of venereal disease to endeavour to obtain the name of the source of infection and also that of any contact. Although this is often a difficult task, and occasionally impossible, we are convinced that in a great many instances no sufficient attempt has been made. Even if the name cannot be obtained, it is often possible by patient and sympathetic questioning to get a sufficient description which may lead to identification.

65. Various estimates have been given to us of the proportion of defaulters but we feel that until the system of recording is put on a better basis it is impossible to compute a reliable defaulter rate ; those who migrate elsewhere, for example, without notifying the clinic are likely to be held in default although they may be continuing treatment. With sulphonamide therapy, gonorrhœa can generally be cured before there is an opportunity to default, but with early syphilis, we are informed, a considerable proportion of patients default, before completing a course of treatment.

66. Default may be encouraged by the black-out, change of employment, late working hours, etc., factors which make attendance at a clinic inconvenient and which may make it difficult for the patient to explain his late arrival home. Other cases, once the external evidences of disease are removed, do not appreciate the need for continued treatment and a few cease to attend when they get knowledge of a negative laboratory result. We are aware, however, that not infrequently patients default as a result of painful injections or some untoward reaction occurring during the course of treatment. In this connection we stress the necessity for extreme care in administering treatment and for showing the utmost consideration to and a sympathetic interest in every individual patient.

67. The importance of bringing contacts to treatment and defaulters to resume treatment cannot be exaggerated and therefore the methods and personnel employed require careful consideration. We have already indicated that the staff used for this work should be those actually engaged in the work of a treatment centre, individuals with tact and personality, with special training for the specific purpose (paras. 60–62).

68. We recommend that the Department of Health for Scotland should ensure that the tracing of contacts and the following up of defaulters is actively pursued, and that arrangements are made on the lines we have indicated for the training and selection of personnel. We would also stress the need for maintaining the zeal and interest of all workers in the field lest the daily routine should stifle enthusiasm and initiative.

69. Under the present system there is great difficulty in securing the attendance of defaulters and in tracing contacts, even where energetic staffs have applied themselves to this difficult task. In our view there is need for strengthening the hands of the Authorities and we have proposals to make when we deal with legislation which should prove of assistance in dealing with this problem.

PREVENTION AND TREATMENT AMONG SEAMEN

70. The prevention and treatment of venereal diseases among personnel of the Merchant Navy constitute a special problem owing to difficulties peculiar to their circumstances. Many of these men spend long periods at sea with brief spells ashore which in wartime may mean the only hours of mental and physical relaxation in between days and nights of continued strain and hazard. With very few clubs or hostels affording rest, comfort and recreation in most areas, the seaman ashore only too often must of necessity spend his leave in dockside areas where there is a profusion of public houses of an unattractive nature ; when these close at 10 p.m. the men have only their ship to return to and many are easy prey to dockside prostitutes who accost them. In peace-time the regular dockside prostitutes are well known and limited in number but since

the war, we are informed, such women go from port to port often with knowledge where numbers of vessels are likely to arrive. Prostitution in seaport towns is a major problem in relation to venereal diseases ; a high percentage of the regular prostitutes are infected and are themselves highly infectious with a high rate of contact exposure.

71. As has been pointed out earlier in this report (para. 4) the value of statistics relating to infected seamen are vitiated by the fact that when a seaman, travelling from port to port, obtains a course of treatment spread over a series of clinics, each may record him as a new patient. Although this inflation of figures obtains in peace-time, the genuine wartime increase is disproportionately magnified and we recommend that steps be taken to rectify the situation.

72. Before the war an infected seaman often preferred to be paid off in order to have the time necessary for continued treatment ; at the present time under the Merchant Navy Pool, all seamen before being allocated to a ship are medically examined and if found to be infected are referred to a panel doctor. A rating ashore, unfit for work by reason of a venereal disease, has to subsist on the National Health Insurance sickness benefit, but officers receive two months pay if off sick for any reason. We are informed that especially if living at home, seamen frequently do not make use of a medical certificate which discloses or even hints at venereal infection. On the other hand, if a man is passed fit for work by the doctor from the Pool whether or not he has a venereal disease, the master of the ship must accept him.

73. Soon after exposure to infection, the seaman may be at sea before symptoms develop and the next port of call may be thousands of miles away. We have been assured, notwithstanding opinions to the contrary, that if no medical officer is aboard, and although masters of ships are provided with drugs and instructions as to their use, the men seldom disclose the fact of their infection to anyone.

74. Clinics in some port areas are in unduly exposed sites, others are difficult to find, and in a few small coastal towns, which are now assembly points with periodic aggregations of ships, there are no local facilities and seamen may have to travel a considerable distance to obtain treatment. While ships are at an anchorage, seamen patients may find it impossible to attend the nearest clinic because convoys may sail at short notice or because tenders to and from the shore sail at unsuitable times. In some areas there may be difficulty if specimens for laboratory examinations have to be sent elsewhere ; reports may not be to hand within a week or even longer, by which time a seaman may have had to rejoin his ship.

75. Every seaman patient is given an International Travelling Card (V.44) on which details of treatment are recorded but the accuracy and amount of information given varies greatly ; judging by examples which we have seen, few of these cards are completed in a satisfactory manner. Instructions should be issued to every treatment centre to ensure that entries on V.44 cards are accurate and sufficiently detailed to form an intelligible clinical record.

76. Cases among men on deep-sea service in ships carrying no surgeon, where symptoms first appear after sailing, are supposed to report to the master who is given a supply of sulphonamides with directions for their administration in accordance with a scheme of treatment agreed upon by the medical authorities of the Allied nations ; where a ship's surgeon is available with

necessary facilities, antisyphilitic treatment may be started after specimens for laboratory examination have been taken. At the very best, treatment is admittedly a compromise between the ideal and what is possible and expedient in the interests of the man, having regard to the exigencies of the shipping situation, but it is evident that although sulphonamide treatment for gonorrhœa can readily be obtained, treatment for the seaman who develops syphilis while at sea may be delayed for a considerable time. The dangers of inefficient and incomplete treatment with the production of the symptomless but still infective case and the development of sulphonamide-resistant gonococci are much more likely to occur among merchant seamen than among landsmen.

77. The plea for prophylactic facilities is in our opinion much more justified in the case of seamen than for the community generally and we consider that the matter should be given priority in the consideration of the problem of prophylaxis to which we have referred (paras. 25-26).

78. There is very little evidence in the case of seamen that contacts are located to any extent, probably because of such factors as intoxication, the blackout and the fact that infection may have been acquired from a complete stranger. While we recognise the difficulty we feel that, as the number of prostitutes and other promiscuous persons who regularly frequent dock areas is somewhat limited, a determined attempt to locate contacts would be of the greatest value, especially if there is an informal but close co-operation between the clinics and the police.

79. We have been told that details of the location of clinics and hours of attendance are advertised by means of posters in different languages in the dock areas and by literature distributed by Port officials who board incoming ships ; in addition leaflets are available giving similar details of clinics at all British ports, and, for foreign-bound ships at ports abroad. We have doubts as to the extent to which this is in fact being done.

80. In making our recommendations for improvement in the prevention and control of venereal diseases among merchant seamen we realise that the problem is closely bound up with the question of better conditions, including medical facilities, for the Merchant Navy as a whole. On shore there is urgent need for an adequate number of clubs and hostels for seamen, situated well away from dock areas, providing reasonable standards of comfort and social amenities at all hours of the day and night.

81. The Department of Health for Scotland and Local Authorities should review existing facilities in port areas to ensure that arrangements for the treatment of seamen are adequate and to eliminate any undue delay in diagnosis.

82. A special effort should be made to locate sources of infection in the port areas. In this connection our recommendations for legislation should be of the greatest assistance.

83. Much of what we have said about propaganda and education requires a particular application to the circumstances of the Merchant Navy, especially those sections dealing with the need for seeking advice and treatment at the earliest possible moment. Masters should be left in no doubt as to their responsibility in encouraging seamen to report immediately when infected and as to the need for strict observance of the scheduled treatment. We further recommend that masters should receive some training in those methods of treatment of venereal diseases which they may have to carry out on board ships.

LEGISLATION

84. A definite step forward was made by the introduction of Regulation 33B of the Defence (General) Regulations, 1939* whereby, under due safeguards, compulsory treatment of promiscuous persons who spread infection is made a statutory obligation. Under the Regulation action is limited to the case where a person is the probable source of infection common to at least two known patients and has been unresponsive to all persuasive methods. So far as we are aware no prosecution under the Regulation has occurred in Scotland and we are satisfied that the medical authorities have shown the greatest discretion in dealing with notifications. There can be no doubt that when both the letter and the spirit of the Regulation are followed, the malicious incrimination of an innocent person is a very remote possibility. Experience has shown that although Regulation 33B has fallen far short of its ostensible purpose, much good has come out of it because, where adequate particulars of identity have been forthcoming in single notifications, informal action has led to the location and follow-up in a fair proportion of instances with a real measure of success.

85. Medical officers with wide experience have represented to us that Regulation 33B does not go far enough to bring the spread of venereal diseases under control. Their chief problem is the intractable defaulter who transmits infection to others and against whom some form of legal sanction is necessary to require continuance of treatment if persuasive methods fail. Although due acknowledgment is given to the improvement effected by the voluntary system in this country, it has been stressed that the results have not been commensurate with the time and labour expended and that it has proved unable to cope with the conditions now prevailing. Most of those with whom we conferred favour some system of notification but some of the opinions expressed were not always fully informed, especially with reference to what notification by itself can accomplish. Notification is impossible until the patient seeks medical advice and a clinical diagnosis is established or, at least, presumed. In respect, therefore, of the first problem, which is to bring infected persons to treatment, notification by itself is of no value.

86. The second problem is to keep the patient under treatment until cured and to locate the source of infection and other contacts. Provided the patient voluntarily submits to treatment, notification by name need not be invoked and we cannot see how notification in itself will assist in bringing in contacts because this depends upon the information volunteered by the patient. We are of the opinion that the matter of contacts should be kept as far removed as possible from any atmosphere of accusation or censure.

87. A third problem arises where the patient refuses, after diagnosis is established, to continue with treatment while still infective. To prevent the spread of disease from such persons some form of legal power should be placed in the hands of the health authorities. At the present time Regulation 33B allows action to be taken against certain persons on the grounds that by their refusal to place themselves under medical care they remain a focus of infection. There can be no question that if associated with authority to deal with defaulters and the infected promiscuous person, notification would do much to combat the spread of venereal diseases.

** Regulations inserted by S.R.&O., 1942, No. 2277.*

88. In a detailed examination of the proposal that every established case of venereal infection should be notified, we have weighed carefully certain arguments to the contrary. Such a procedure, it is suggested, might drive venereal disease underground ; against this we place the view that the majority of sufferers wish to be cured and if they are assured that this can be done in strict confidence they will not hesitate to seek treatment.

It is also suggested that medical practitioners will not readily notify cases of venereal disease. The type of notification which we contemplate, however, is designed not to penalise the patient but to bring to his assistance the full resources of medical science. There need be no fear that notification of venereal diseases will place an undue burden upon doctors because the number of infected patients in a single private practice is small and should become progressively less.

89. We recommend that legislation be devised to require notification of every established case of venereal disease, and to give increased power to the health authorities, while maintaining strict anonymity for the patient who co-operates and respects his obligations. When a patient refuses to respect these obligations by continued default he becomes a potential public menace and the privilege of secrecy should be preserved no longer, and, when all reasonable persuasion has failed, prosecution must be considered. We feel that the threat of publicity inherent in such circumstances will act as a powerful deterrent and that actual prosecution will seldom be required.

90. When a practitioner, whether in public or private practice, is satisfied that a patient is suffering from a venereal disease, he should notify the Medical Officer of Health in code and indicate whether he himself is undertaking the treatment or how he has disposed of the case, e.g. by reference to a treatment centre or special practitioner. Where the notification states that the patient has been referred to a centre for treatment, the Medical Officer of Health should take steps to verify that the patient has attended ; in the case of non-attendance the notifying practitioner will be informed and given the opportunity of again seeing the patient or of requesting the Medical Officer of Health to act.

91. Once the diagnosis is established the practitioner must inform the patient that he suffers from a specified venereal disease and that he must continue treatment until he receives a clearance certificate. In this connection we recognise that there may be considerable difficulty in cases of marital infection but we are of the opinion that in these circumstances the doctor as a matter of professional duty, should advise a frank confession and, if necessary, arrange for a conference between the parties and himself in order to explain the situation and to give any necessary advice.

92. Where a practitioner has reasonable grounds for believing that a patient has discontinued treatment without due and sufficient cause, and has failed to persuade him to resume, he must notify the Medical Officer of Health who shall take such steps as are deemed necessary to bring the patient to treatment in accordance with the principles laid down in Section 5 of Appendix B to D.H.S. Circular No. 2/1943. Where there is persistent refusal after all due persuasion, the case should be reported to the Procurator Fiscal.

93. The foregoing procedure should be suitably adapted to meet the case of gonorrhœal ophthalmia neonatorum and of congenital syphilis in children whereby the parents shall be deemed to be suffering from gonorrhœa or syphilis as the case may be and, unless on health grounds this be considered inadvisable, they should be duly informed of the fact and required to submit to examination

and treatment. We think it would be advisable to allow for appeal to a medical referee appointed by the Department of Health for Scotland where any parent or guardian feels aggrieved by a diagnosis of venereal disease by the notifying practitioner.

94. We have given careful consideration to the question whether it is desirable to give legal authority to a Medical Officer of Health to require an individual, alleged to have been the source of infection to a patient already notified, to submit to examination. We do not think this advisable, however; until the alleged source of infection has been examined by a medical practitioner there can be no evidence that the individual does in fact suffer from a venereal disease and we are convinced that in the location and treatment of contacts recourse must be had to methods of persuasion.

95. Notwithstanding the observations and conclusion of the preceding paragraph we recommend that the powers conferred by Regulation 33B be continued for cases of multiple notification of a source of infection. After detailed investigation we are satisfied that the Regulation has been operated with tact and discretion and that the fears of unfairness or oppression expressed at its inception have proved groundless.

I have the honour to be, SIR,

Your obedient Servant,

(Signed) JOHN FRASER (*Chairman*).
On behalf of The Medical Advisory Committee (Scotland).

ST. ANDREW'S HOUSE,
EDINBURGH, 1.
21*st December*, 1943.

APPENDIX

TABLE I

RETURNS FROM TREATMENT CENTRES, 1933-1942.

Year.	Syphilis New Cases.			Gonorrhœa New Cases.			Soft Chancre.			Non-Specific V.D.			Non-Venereal Conditions.		
	Primary.	Secondary.	Late.	Total.	M.	F.	Total.	M.	F.	Total.	M.	F.	Total.	M.	F.
1933 . . .	496	399	1,524	5,566	4,094	1,472	154	153	1	2,439	1,330	1,109	4,636	2,561	2,075
1934 . . .	513	370	1,420	5,757	4,303	1,454	258	256	2	2,575	1,446	1,129	4,638	2,679	1,959
1935 . . .	481	402	1,340	5,854	4,430	1,424	256	255	1	2,600	1,550	1,050	4,111	2,291	1,820
1936 . . .	547	367	1,332	6,155	4,446	1,709	198	198	—	2,602	1,554	1,048	4,101	2,397	1,704
1937 . . .	601	450	1,264	5,695	4,196	1,499	364	358	6	3,149	1,748	1,401	4,014	2,222	1,792
1938 . . .	484	437	1,391	5,280	4,030	1,250	281	275	6	3,000	1,768	1,232	4,677	2,368	2,309
1939 . . .	669	354	1,060	4,279	3,303	976	206	201	5	2,849	1,647	1,202	3,965	2,186	1,779
1940 . . .	825	563	932	4,491	3,605	886	229	225	4	2,730	1,721	1,009	3,828	2,074	1,754
1941 . . .	1,776	939	1,023	6,451	5,260	1,191	356	352	4	3,169	2,160	1,009	4,565	2,462	2,103
1942 . . .	2,238	1,499	1,150	5,795	4,543	1,253	227	223	4	2,616	1,824	792	5,044	2,741	2,303

TABLE II

NEW CASES AT TREATMENT CENTRES.

Comparison of 15-25 age-group with older ages.

Year.	Syphilis. Male. 15–25 group.	Syphilis. Male. 25+ group.	Syphilis. Female. 15–25 group.	Syphilis. Female. 25+ group.	Year.	Gonorrhœa. Male. 15–25 group.	Gonorrhœa. Male. 25+ group.	Gonorrhœa. Female. 15–25 group.	Gonorrhœa. Female. 25+ group.	Year.	Totals. 15–25 group.	Totals. 25+ group.
1939	230	1114	299	724	1939	779	2505	379	530	1939	1687	4873
1940	291	1300	293	644	1940	866	2709	369	451	1940	1819	5104
1941	782	1955	391	773	1941	1962	3292	479	648	1941	3614	6668
1942	1065	2447	571	945	1942	1531	3008	513	670	1942	3680	7070

TABLE III

CONGENITAL SYPHILIS.

Annual Returns from Local Authorities.

Age Groups.	1933 M.	1933 F.	1934 M.	1934 F.	1935 M.	1935 F.	1936 M.	1936 F.	1937 M.	1937 F.	1938 M.	1938 F.	1939 M.	1939 F.	1940 M.	1940 F.	1941 M.	1941 F.	1942 M.	1942 F.
0–1 . . .	50	114	51	110	49	89	38	100	42	94	52	122	43	91	29	71	25	67	19	66
1–5 . . .	26	29	38	38	26	28	11	37	17	41	24	45	11	35	5	17	2	24	7	18
5–15 . . .	57	122	62	103	42	90	47	103	48	84	61	89	31	58	14	52	15	31	22	30
15–25 . . .	58	104	64	100	53	79	51	90	58	92	51	80	38	100	28	69	37	59	42	57
25+ . . .	31	50	22	70	22	62	15	48	22	77	21	76	21	69	16	57	34	58	21	37
Total . . .	222	419	237	421	192	348	162	378	187	388	209	412	144	353	92	266	113	239	111	208
Combined Total .	641		658		540		540		575		621		497		358		352		319	

TABLE IV

OPHTHALMIA NEONATORUM.

In evaluating the total notifications it must be remembered that all cases showing inflammatory conjunctival lesion are reported. The number due to gonococcal infection cannot be ascertained.

Notified Cases—1933–1942.

	No. notified.	*Removed to Hospital.*	*Cases with appreciable loss of vision.*		
			No. reported.	*Proven gonococcal infection.*	*Infection not gonococcal or not ascertained.*
1933	1,472	183	7	5	2
1934	1,481	235	5	5	–
1935	1,345	213	5	5	–
1936	1,379	252	5	4	1
1937	1,732	255	7	4	3
1938	1,705	236	3	3	–
1939	1,328	278	–	–	–
1940	1,152	163	1	1	–
1941	908	162	–	–	–
1942	1,011*	Not available†	1	–	1

* Provisional figures.

† i.e., When Report was completed.

FIG. 1. SYPHILIS
New cases at Scottish clinics, 1922-1942

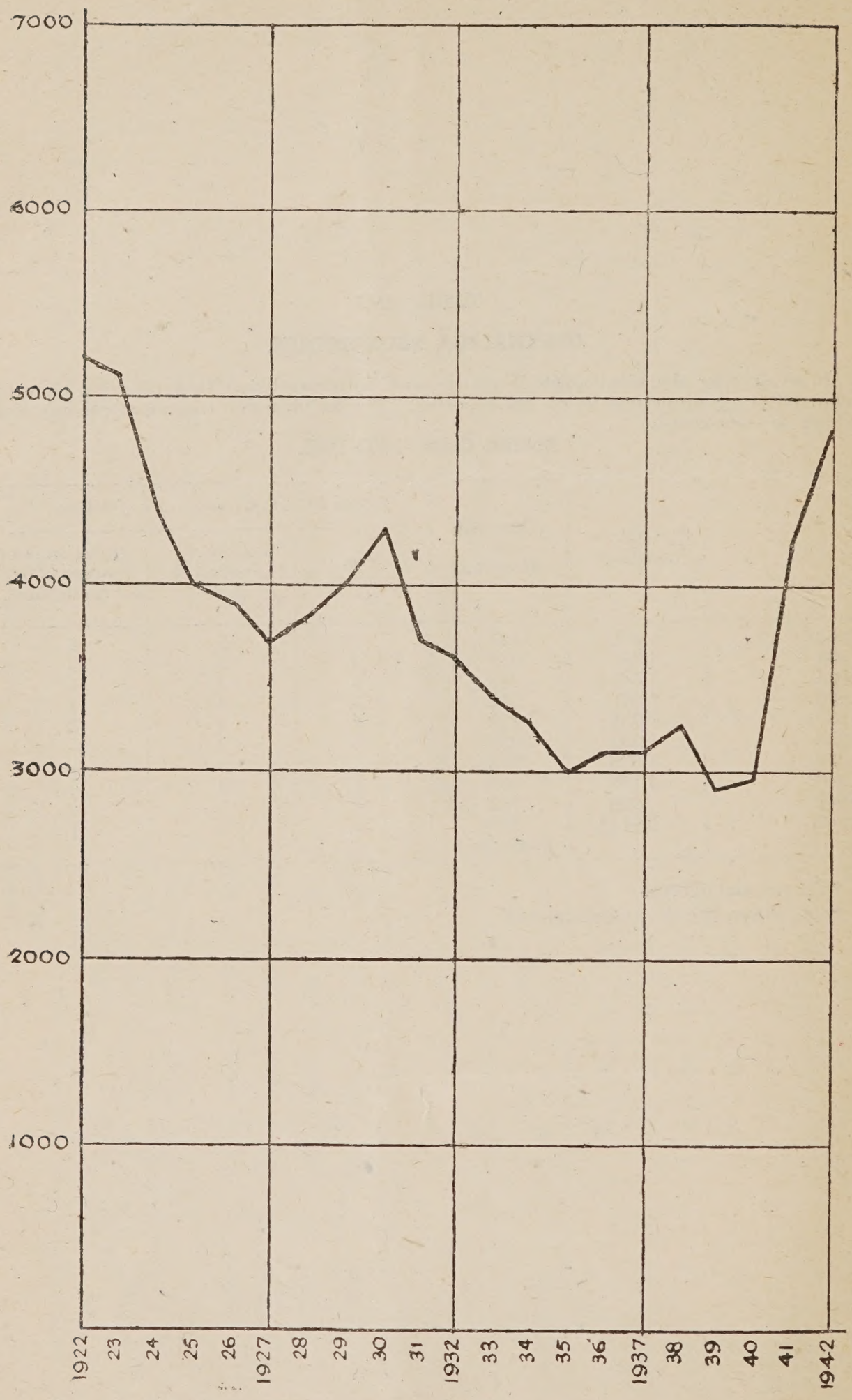


FIG 2. GONORRHŒA
New cases at Scottish clinics, 1922-1942

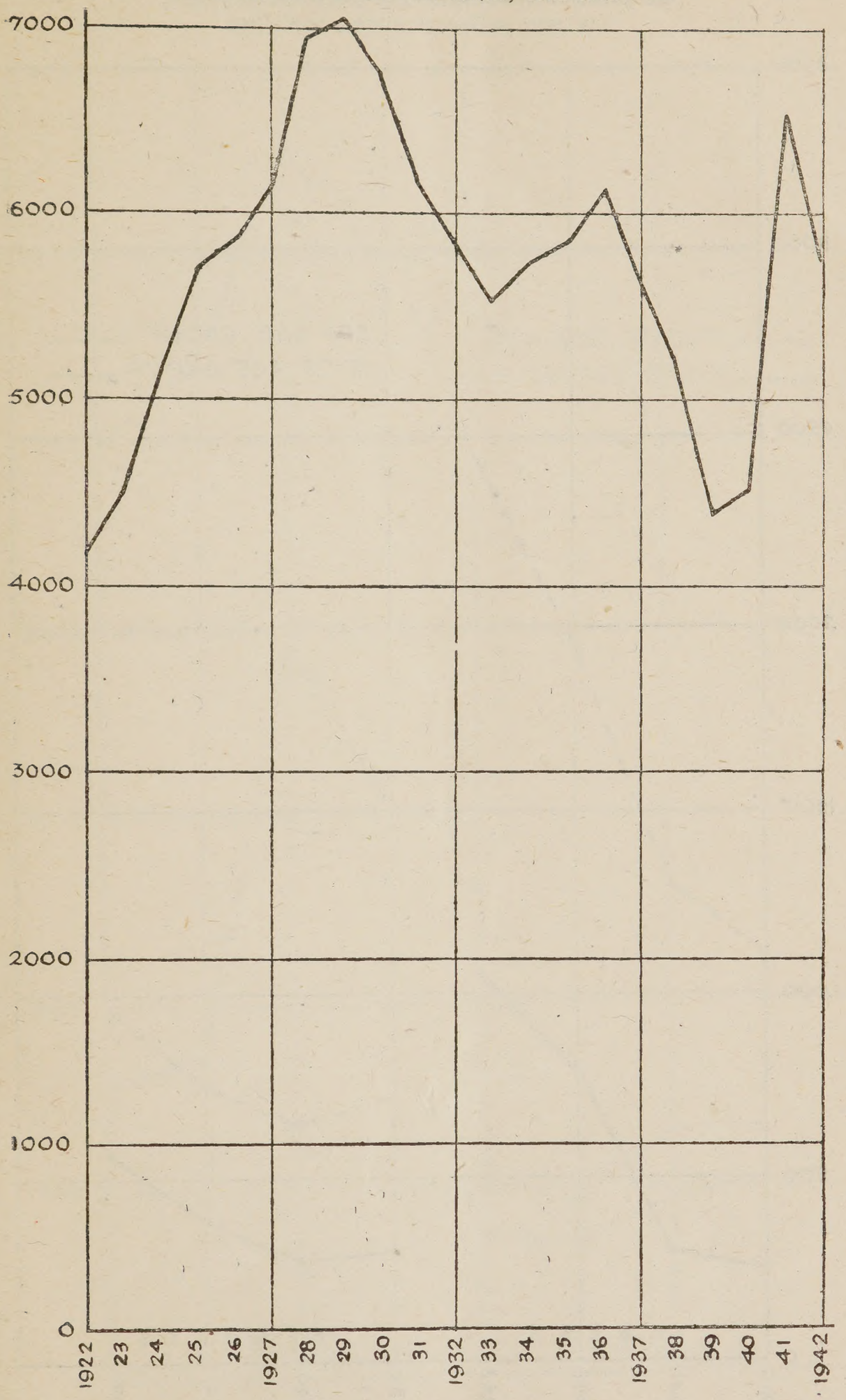


FIG. 3.—SYPHILIS

Comparison between 15-25 Age-group and older ages.
New cases at Scottish clinics, 1939–1942.

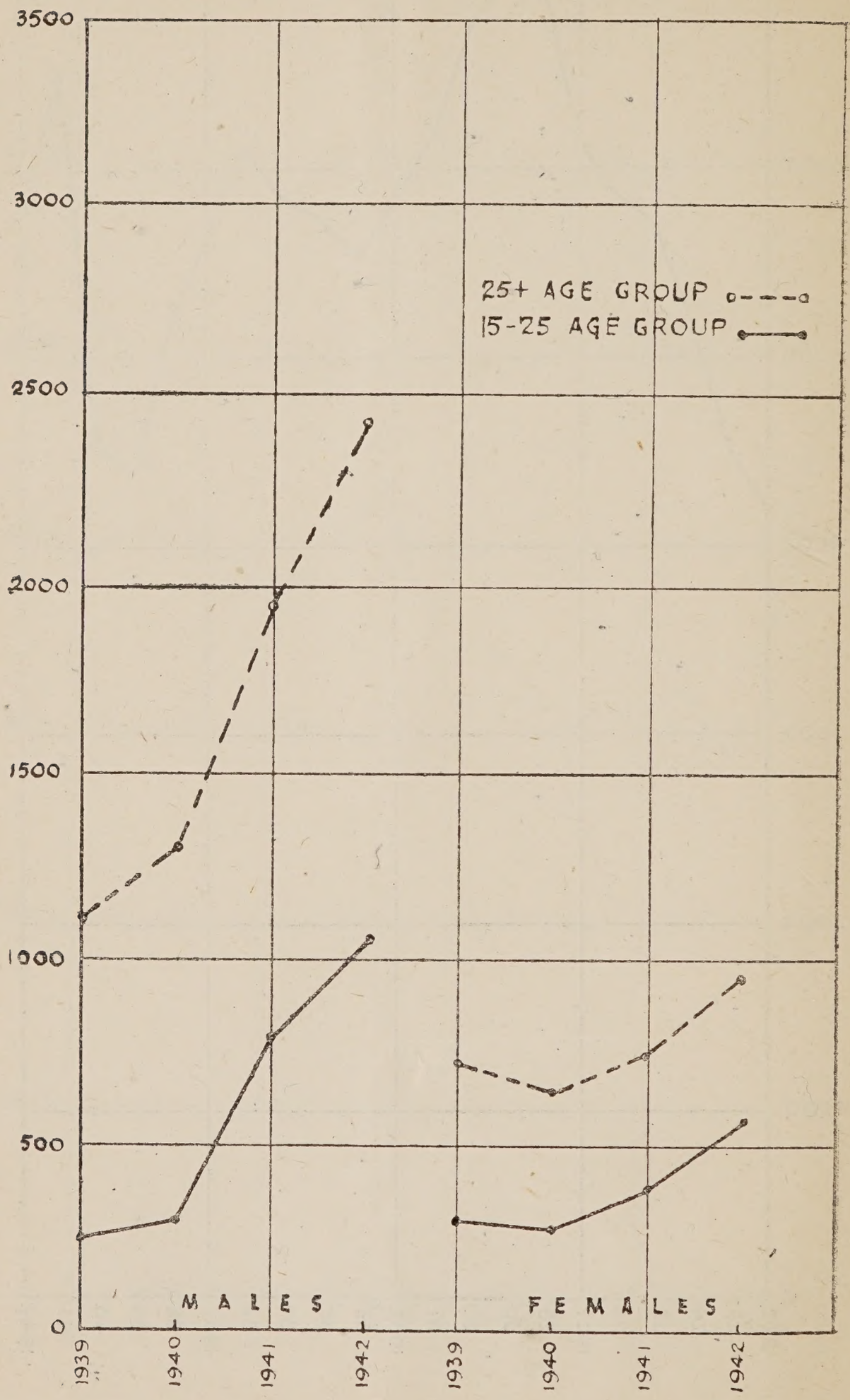
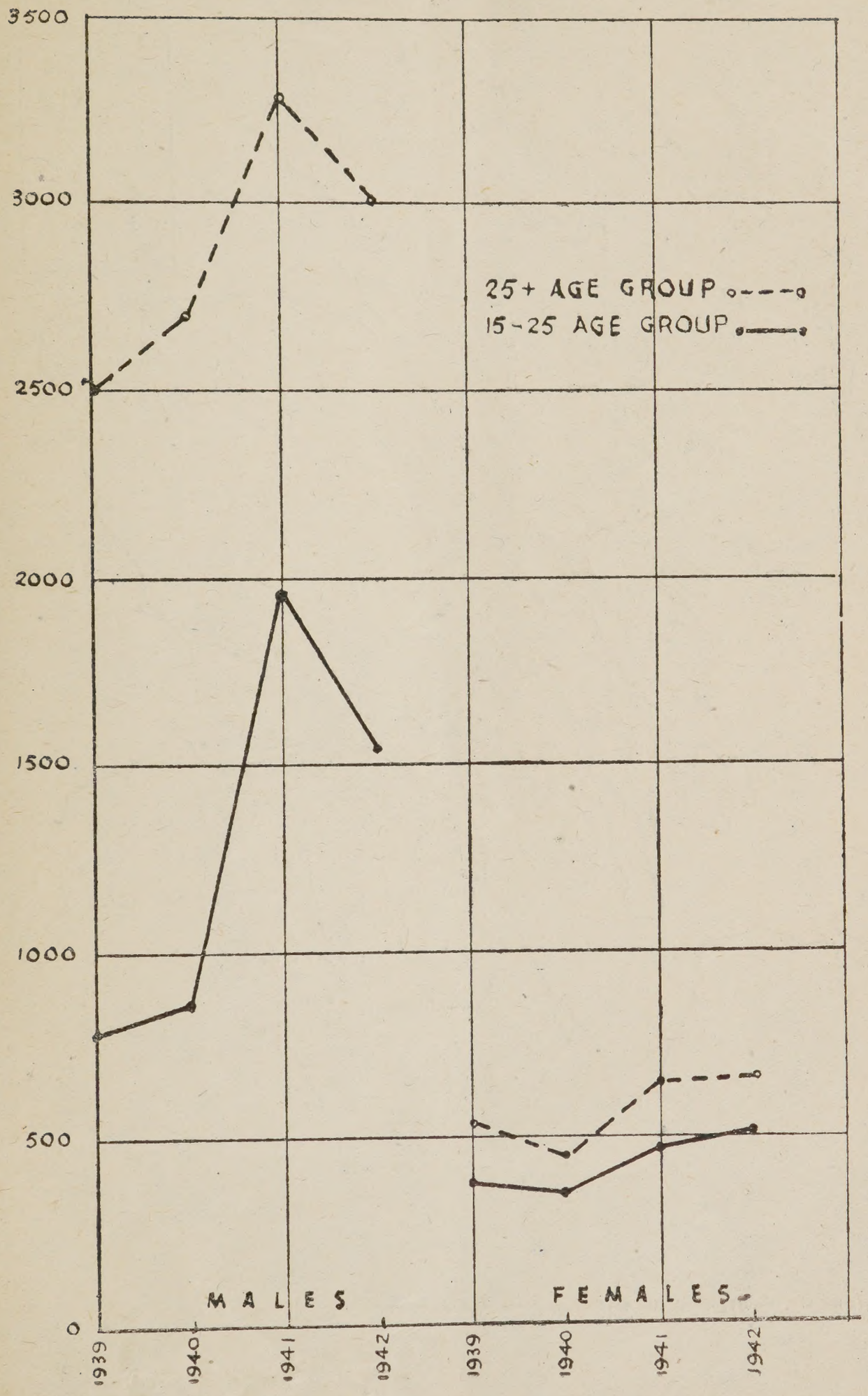


FIG. 4.—GONORRHŒA

Comparison between 15–25 Age-group and older ages.
New cases at Scottish clinics, 1939–1942.



GEOGRAPHICAL DISTRIBUTION OF APPROVED TREATMENT CENTRES

(1100) Wt. 3880/1765 2540 4/44 J. & J. G. G.170